TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
DOCTORS HOSPITAL AT RENAISSANCE

Respondent Name
HIDALGO COUNTY

MFDR Tracking Number
M4-17-1986-01

Carrier's Austin Representative
Box Number 21

MFDR Date Received
February 28, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "After reviewing the account we have concluded that reimbursement received was inaccurate."

Amount in Dispute: $965.87

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "reimbursement made is in line with the current Workers Compensation Fee Schedule within Medicare guidelines and under . . . the Multiply Procedure Payment Reduction . . . on selected therapy services to 50% . . . The reduction applies to . . . codes contained on the list of 'always therapy' services that are paid under the physician fee schedule, regardless of the type of provider . . . that furnishes the services."

Response Submitted by: IMO, Injury Management Organization, Inc.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 8, 2016 to September 26, 2016	Outpatient Hospital Services	$965.87	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the acute care hospital fee guideline for outpatient services.
3. 28 Texas Administrative Code §134.203 sets out the fee guideline for professional medical services.

4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 222 – Charge exceeds Fee Schedule allowance
   - 240 – Charge reviewed to multiple procedure ground rules
   - 592 – 0 percent impaired, limited or restricted
   - 779 – Items, codes and services that are not covered by Medicare.
   - 59 – Processed based on multiple or concurrent procedure rules.
   - P12 – Workers compensation jurisdictional fee schedule adjustment.
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - W3 – [No description of this claim adjustment reason code found with the submitted materials.]

Issues

1. What is the applicable rule for determining reimbursement for the disputed services?
2. What is the recommended payment amount for the services in dispute?
3. Is the requestor entitled to additional reimbursement?

Findings

1. This dispute regards outpatient hospital facility services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule.

   Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested.

2. Medicare's Outpatient Prospective Payment System (OPPS) assigns an Ambulatory Payment Classification (APC) for billed services based on procedure codes and supporting documentation. The APC determines the payment rate. Hospitals may be paid for more than one APC per encounter. Payment for ancillary items and services without procedure codes is packaged into the payment for the APC. The Centers for Medicare and Medicaid Services (CMS) publishes quarterly lists of APC rates in the OPPS final rules, available from www.cms.gov. Reimbursement for the disputed services is calculated as follows:

   - Procedure code 97035, September 8, 2016, has status indicator A, denoting services paid by fee schedule or different payment system from OPPS. If Medicare pays using other systems, Rule §134.403(h) requires use of the division fee guideline applicable to the item on the date provided. Professional services are paid using the DWC Professional Medical Fee Guideline, Rule §134.203(c). Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, the first unit of the procedure with the highest practice expense is paid in full. Payment for the practice expense of each subsequent unit is reduced by 50%. This procedure does not have the highest practice expense for this date. The reduced rate is $9.96. This amount divided by the Medicare conversion factor of 35.8279 and multiplied by the DWC conversion factor of 56.82 yields a MAR of $15.80.
   - Procedure code 97140, September 8, 2016, has status indicator A. This procedure does not have the highest practice expense for this date. The reduced rate for this code is $22.29. This amount divided by the Medicare conversion factor of 35.8279 and multiplied by the DWC conversion factor of 56.82 yields a MAR of $35.35.
   - Procedure code 97112, September 8, 2016, has status indicator A. This procedure has the highest practice expense for this date. The Medicare rate is $32.53. Each additional unit is paid at $24.62. Medicare's payment rate for 2 units is $57.16. This amount divided by the Medicare conversion factor of 35.8279 and multiplied by the DWC conversion factor of 56.82 yields a MAR of $90.64.

- Procedure code 97035, September 13, 2016, has status indicator A. This procedure does not have the highest practice expense for this date. The reduced rate is $9.96. This amount divided by the Medicare conversion factor of 35.8279 and multiplied by the DWC conversion factor of 56.82 yields a MAR of $15.80.
- Procedure code 97112, September 13, 2016, has the highest practice expense for this date. The Medicare rate is $32.53. This amount divided by the Medicare conversion factor of 35.8279 and multiplied by the DWC conversion factor of 56.82 yields a MAR of $51.59.
- Procedure code 97110, September 13, 2016, has status indicator A. This procedure does not have the highest practice expense for this date. The reduced rate is $23.96. This amount multiplied by 2 units is $47.93. This amount divided by the Medicare conversion factor of 35.8279 and multiplied by the DWC conversion factor of 56.82 yields a MAR of $76.01.
- Procedure code 97112, September 15, 2016, has the highest practice expense for this date. The Medicare rate is $32.53. This amount divided by the Medicare conversion factor of 35.8279 and multiplied by the DWC conversion factor of 56.82 yields a MAR of $51.59.
- Procedure code 97110, September 15, 2016, does not have the highest practice expense for this date. The reduced rate is $23.96. This amount multiplied by 3 units is $71.89. This amount divided by the Medicare conversion factor of 35.8279 and multiplied by the DWC conversion factor of 56.82 yields a MAR of $114.01.
- Procedure code 97112, September 19, 2016, has the highest practice expense for this date. The Medicare rate is $32.53. This amount divided by the Medicare conversion factor of 35.8279 and multiplied by the DWC conversion factor of 56.82 yields a MAR of $51.59.
- Procedure code 97110, September 19, 2016, does not have the highest practice expense for this date. The reduced rate is $23.96. This amount multiplied by 3 units is $71.89. This amount divided by the Medicare conversion factor of 35.8279 and multiplied by the DWC conversion factor of 56.82 yields a MAR of $114.01.
- Procedure code 97112, September 21, 2016, has the highest practice expense for this date. The Medicare rate is $32.53. This amount divided by the Medicare conversion factor of 35.8279 and multiplied by the DWC conversion factor of 56.82 yields a MAR of $51.59.
- Procedure code 97110, September 21, 2016, does not have the highest practice expense for this date. The reduced rate is $23.96. This amount multiplied by 3 units is $71.89. This amount divided by the Medicare conversion factor of 35.8279 and multiplied by the DWC conversion factor of 56.82 yields a MAR of $114.01
- Procedure code 97002, September 26, 2016, has status indicator A. The Medicare rate is $40.54. This amount divided by the Medicare conversion factor of 35.8279 and multiplied by the DWC conversion factor of 56.82 yields a MAR of $64.30
- Procedure codes G8978 and G8979, September 26, 2016, have status indicator E, denoting excluded or non-covered codes. These are functional status codes required by Medicare payment policy to be reported on the bill for informational purposes only. These codes have no separate payment.

3. The total recommended reimbursement for the disputed services is $846.29. The insurance carrier has paid $846.77 leaving an amount due to the requestor of $0.00. Additional payment is not recommended.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.

The Division would like to emphasize that the findings and decision in this dispute are based on the evidence presented by the requestor and respondent available at the time of review. Even though all the evidence was not discussed, it was considered.

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	March 27, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.